Washington State Department of Social & Health Services
MAA Medical Assistance Administration

HOSPITAL BED EVALUATION

NOTE: Do not alter this form in any way. This form may only be completed by a qualified provider, acting within the scope of their practice as required by WAC 388-543-1100(1)(d), and all spaces must be completed. A signed and dated form is required for each authorized rental period. **This form is required in addition to a prescription.**

SECTION I

CLIENT NAME	CLIENT PIC	DATE OF REQUEST

What is the diagnosis/medical condition that requires the use of a hospital bed? (Do not use ICD9 codes for the diagnosis.)

LENGTH OF NEED IN MONTHS OR YEARS	HOURS PER DAY CLIENT IS IN BED	HOURS PER DAY A CAREGIVER IS IN ATTENDENCE	HOURS PER DAY CLIENT UTILIZES A WHEELCHAIR

SECTION II

Hospital Bed Requested: ☐ Manual ☐ Semi-Electric ☐ Full-Electric ☐ Heavy Duty

Does the client require the head of the bed to be elevated greater than 30 degrees for more than 50% of the time due to a respiratory condition? ☐ Yes ☐ No If yes, please describe the type and severity of the respiratory condition.

Have pillows, bolsters, foam wedges, or rolled-up towels been tried? ☐ Yes ☐ No What were the outcomes and if not successful, why?

Why would a manual hospital bed not meet the client's needs:

Does the client require immediate (emergent) position change? ☐ Yes ☐ No If yes, please explain.

Is the client at risk for aspiration? ☐ Yes ☐ No If yes, what is the cause and frequency?

Is client tube fed? ☐ Yes ☐ No	Is client on oxygen? ☐ Yes ☐ No If yes, continuous or intermittent?

Does the client require Trendelenburg position? ☐ Yes ☐ No If yes, please explain.

For heavy duty hospital bed: What is the client's weight? _____

If the client is under 420 lbs., what is the measurement from side to side at the widest part of the body? _____

SECTION III

Additional Comments:

SECTION IV

PHYSICIAN'S PRINTED NAME	REFERRING PHYSICIAN'S NUMBER

PHYSICIAN'S TELEPHONE NUMBER	PHYSICIAN'S FAX NUMBER

PHYSICIAN'S SIGNATURE	DATE:

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